

Medicaid and CHIP Performance Indicators

Compendium of State Questions and CMS Answers by Indicator

December 6, 2013

This document compiles previously released questions and answers regarding the Medicaid and CHIP performance indicators. New questions and answers are identified by the symbol, “ * ”. As we receive new questions from states, we will continually update this document.

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General Questions

- 1. Should these indicators include all applications/determinations/enrollees, or only the newly-eligible population who applied and were determined under the new MAGI rules?***

Each indicator should include all applications, determinations, and enrollees for the state's entire Medicaid and Children's Health Insurance Program (CHIP), including both those processed under modified adjusted gross income (MAGI) and non-MAGI rules. These performance indicators are part of a broader effort to better understand the Medicaid program nationwide. We hope that the data generated will give states and the Centers for Medicare & Medicaid Services (CMS) a common understanding of eligibility and enrollment processes within and across all states and all populations.

- 2. Are the indicators the same ones as those reported by the state-based marketplace (SBM)? It looks like the same information.***

No, these are not the same indicators. The Medicaid and CHIP performance indicators were developed to allow CMS and states to monitor the streamlined eligibility and enrollment processes for Medicaid and CHIP programs in every state, regardless of whether or not the state implemented a state-based marketplace (SBM). To the extent possible, CMS has worked to align definitions on the Medicaid and CHIP performance measures with the definitions that the Center for Consumer Information and Insurance Oversight (CCIIO) is using in the metrics it is asking SBMs to report. The close similarity between certain Medicaid/CHIP and SBM measures is a result of this alignment process. However, since not all Medicaid and CHIP enrollees will apply or enroll through SBMs, we are asking all state Medicaid and CHIP programs to report this data for their program.

- 3. Do the terms "SBM" and "insurance exchange" refer to the same thing?***

"SBM" stands for "State Based Marketplace," which is another term for the state-based health insurance exchanges. "FFM" stands for "Federally Facilitated Marketplace," which is the term for the insurance exchange run by the federal government.

- 4. Our legacy application or eligibility determination system cannot provide the break-outs you are requesting. Should we wait to submit the data until we are able to provide those break-outs?***

No, please submit the "top-line" numbers for each indicator now, and provide other data as it becomes available to you. We understand that given systems limitations, many states might not be able to provide all the data break-outs at this point. However, this information is important to CMS and to states in answering key questions regarding Medicaid and CHIP eligibility and enrollment. As systems are updated, please incorporate these important operations performance indicators into your reporting abilities.

5. *When states need to use the data limitations field to provide context for their data, does this need to be done each week, even if the context provided will be the same every week?*

Within the Socrata system, the only information that carries over from week to week is the description of call centers. As such, anything entered in the data limitations field will need to be re-entered from week to week. Alternatively, a state may reference the data limitations field entered in a previous week (please include the date of the weekly/monthly report being referenced). If the data limitations change in any meaningful way, such as it becomes possible to report breakout data that had not previously been available, the data limitations field should be updated in the first report to which the change applies.

Reporting Logistics

1. *What is the timeline for submitting data?*

Baseline data. States should have submitted the July and August monthly baseline data for the indicators by Thursday, September 26. States should have submitted the September baseline data by Tuesday, October 8 using the excel spreadsheet referenced below.

Weekly data. States should have begun submitting weekly post-implementation data on Tuesday, October 8. This data should be reported **every Tuesday** for the previous week (running Sunday-Saturday) through the open enrollment period, which ends March 31, 2014.

Monthly data. States should have begun submitting monthly post-implementation data (indicators #5-12) starting on November 8. Going forward, this data should be reported on **the 8th of every month** following the previous calendar month. As the 8th, falls on a Sunday in December, we are asking states to submit data on Friday, December 6th. States must also update all their prior month indicators (with the exception of indicators 1-3, which relate to call centers and indicator #4 which relates to weekly application counts) when they submit the subsequent monthly report. For example, when submitting the November monthly report (on December 6th), the state should also update its October data to show any retroactive enrollments or other adjustments. When submitting its December report, the state need not update any data from October, but it must update its November monthly data.

2. *How should we submit the data to CMS?*

The monthly baseline data (for July, August, and September) should be entered into the data collection template (excel spreadsheet) that was emailed to states on September 20, 2013 and accessible on the CALT website. Please email the completed template to SDIS@cms.hhs.gov.

The post-implementation data is collected through a web-based tool that requires login credentials. Up to five individuals in each state can be given login credentials. To create one or more accounts, please fill out the account creation template (named *CMS Perf. Measures State Account Creation 09 11 2013.xls*) available on CALT, and email the completed document to SDIS@cms.hhs.gov.

Alternatively, you may take the following steps: Please send an email that includes the names, email addresses, your state's abbreviation, and the individual's role (admin or view) to SDIS@cms.hhs.gov. You will receive an email back from Socrata with information about how to access the system. If you do not hear back, please let us know.

Below is an example of the information to include in the email:

<u>Name</u>	<u>Email</u>	<u>State</u>	<u>Role</u>
Jane Doe	Jane.Doe@colorado.gov	CO	State Admin

3. *Why can't you use the baseline spreadsheet to add data for the weekly and monthly reporting?*

If the state finds the Excel baseline spreadsheet easier to use when gathering and organizing the performance indicator data, we encourage them to use this as an internal tool before entering data into Socrata as a last step.

Using the Socrata web-based data entry tool is intended to ease the reporting burden on states, provide a clear way to track the most recent version of the data, and allow both states and CMS to directly access current and previous reports in real time. If there are specific issues that make entering data into Socrata burdensome, we encourage states to communicate those issues to us at **PerformanceindicatorsTA@cms.hhs.gov** and we will work to address those issues in the Socrata tool.

Indicators 1, 2, and 3: Call Center Volume, Average Wait Time, and Abandonment Rate

- 1. Our state does not have a call center, or cannot track call volume and other call statistics because it is handled at the county level where no data is gathered. What should we report in indicators 1-3?***

The purpose of the call center indicators is to understand trends in each state's call centers/phone lines that receive public inquiries for Medicaid and CHIP. We understand that call centers vary considerably by state. If your state does not currently collect all of the information requested, or there is any other context that would be helpful for CMS to know in interpreting the data, please note the reason for this in the data limitations field that accompanies each indicator. Please describe any context that may over or undercount call center volume (indicator 1). For example if your call center(s) receive calls for other public programs outside of Medicaid and CHIP, please describe this in the data limitations field.

- 2. If the Medicaid Agency call center and the SBM call center are integrated (i.e., both handle Medicaid and CHIP calls), can the SBM data be reported in the Medicaid & CHIP performance indicators?***

No. Call centers operated or overseen by the SBM should not be included in the Medicaid & CHIP performance indicators. Data from these call centers will be reported to CCHIO, and we hope to avoid duplication.

- 3. *In our state, the phone line for Medicaid operates 24/7. In the call volume measure, should we report only the calls that occur within the business hours of 8:00 AM - 6:00 PM, Monday through Friday, or should we include the calls that occur outside of those hours as well?***

Please report all calls in indicator 1 (total call volume), even if these calls occur outside of regular business hours. This would most accurately depict the volume and state workload of manning the call center. If your state has any concerns regarding the count, please provide relevant information in the data limitations field.

- 4. Our state has an Automated Response Unit (ARU) that receives and manages many calls automatically without the need to transfer the call to the Call Centers or to talk to an agent. Only a portion of callers find that they need to talk to an agent. In the call volume indicator, should we report data for all calls received at the ARU, including those handled automatically, or should we only report calls transferred to the call centers?***

Yes, please report data for all calls received at the ARU in indicator 1, including those that can be handled solely by an automatic system. This indicator is intended to capture the level of interest in and activity related to Medicaid & CHIP in a state. Therefore, we'd like you to report the total number of calls made by all individuals.

5. *Should all call center wait times be rounded up or down to the nearest whole minute?*

Yes. All call center wait times (indicator 2) should be reported in whole minutes. As an example, if your wait time is 29 seconds, it should be rounded down to zero. If your wait time is one minute and 29 seconds, it should be rounded down to one minute. If it is one minute and 30 seconds, it should be rounded up to two minutes.

Indicators 4 and 5: Total Applications Received

1. ***For “number of applications received” (indicators 4 and 5), are you only looking for people who are applying through the Medicaid agency, or for all individuals applying through other agencies or the Marketplace?***

States should report applications received by any agency in the state (all doorways), including both MAGI and non-MAGI applications, and not just applications received directly by the Medicaid agency. The number of applications received by each agency (Medicaid, separate CHIP agency, and/or state-based marketplace) should be reported separately in indicators 4b, 4c, and 4d (weekly report) or 5b, 5c, and 5d (monthly report). The top-line number of total applications (indicator 4a in the weekly report and indicator 5a in the monthly report) should include all applications received through any door.

2. ****Within the applications indicator, which applications should be included? Should even those applications for disability-related coverage be included?***

States should include, in indicators 4 and 5 (applications received), any application submitted by an applicant that will require a Medicaid or CHIP determination. If the state uses a combined application for some or all Medicaid applicants that also screens individuals for other social service programs (such as SNAP), these applications should be included when Medicaid or CHIP is among the programs the person is being evaluated for. If the state has separate applications for different Medicaid populations (i.e., a family Medicaid application and an ABD application), all applications should be included in these indicators.

3. ***Our state has a new joint Eligibility & Enrollment system for CHIP and Medicaid that happens to sit in the CHIP agency. Did I hear correctly that all of these applications should be reported as Medicaid?***

In the indicators 4a and 5a, states should report the total unduplicated number of applications received during the reporting period (week or month) by any state agency. They should also provide counts of the applications received through each “door” in indicators 4b-d and indicators 5b-d. If most applications for Medicaid and CHIP in your state are received by the CHIP agency before being entered into the joint eligibility & enrollment system, then these applications should be reported in indicator 4c/5c (applications received by CHIP agency). Please include a note in the data limitations field that explains that the new Eligibility and Enrollment system for CHIP and Medicaid resides in the CHIP agency. If some applications are received by the Medicaid agency and some by the CHIP agency before all are entered into the same system, the counts reported in the indicator 4b/5b (applications received by Medicaid agency) and indicator 4c/5c (applications received by CHIP

agency) should reflect which agency received the application regardless of where the eligibility & enrollment system sits.

- 4. *Should transfers be included in the number of applications received (indicators 4 and 5)? If so, what channel should these transfers be reported under?***

States should not include transfers in the number of applications received for indicators 4 and 5, as these should be separately captured in indicator 6 (transfers).

- 5. *Please clarify how FFM transfers are captured in the indicators for number of applications?***

Transfers from the federally-facilitated marketplace (FFM) to states should not be included in indicators 4 and 5. These transfers will instead be counted as applications in the FFM reporting. This is the same regardless of whether the state is an assessment state (where the FFM only assesses Medicaid/CHIP eligibility before transferring to the state for a final eligibility determination) or a determination state (where the FFM makes a final determination of Medicaid/CHIP eligibility and transfers accounts to the state for enrollment).

- 6. **How should we report on individuals whose eligibility information is transferred administratively through a process other than the ones available through the May 17th SMO letter (for example, SSI recipients who are auto-enrolled, or enrollments via Express Lane Eligibility [ELE] programs)? Should these individuals be counted in the applications indicator and/or the determinations indicator?***

Individuals who enter a state's eligibility determination system via an administrative data transfer rather than by submitting an application should not be counted in indicators 4 or 5 (total applications received). This would be the case for SSI recipients who are auto-enrolled into Medicaid; ELE determinations; and transfers from an existing 1115 demonstration.

These individuals should, however, be counted in the determinations reported in indicator 9 (total Medicaid eligible). They should also be reported in 9g (Medicaid eligible via other method), and not in 9f (Medicaid eligible via administrative determination). When states report individuals in indicator 9g (Medicaid eligible via other method), a description of how these individuals were determined eligible (e.g. through ELE processes) should be included in the data limitations field. The only determinations that should be included in element 9f (Medicaid eligible via administrative determination) are those made through the targeted enrollment strategies outlined in the May 17th SMO letter.

- 7. **In our new eligibility system, applicants in the state-based marketplace (SBM) check a box requesting that the system determine whether they are eligible for subsidized coverage, which***

would include both Advanced Premium Tax Credits (APTC) and Medicaid eligibility. Given that the applicant is not distinguishing a request for APTC from an application for Medicaid, how should we capture this activity?

Please capture this activity as an application in indicators 4 and 5. In all SBM states (with one exception, temporarily), the process of applying for and receiving an eligibility determination for subsidies, Medicaid, and CHIP is integrated, so all applications to the SBM requesting a screening for financial assistance should receive a Medicaid or CHIP determination. Given this, when an individual submits an application to the SBM for financial assistance, this application should be counted in indicator 4a (total applications received) in the weekly report and indicator 5a (total applications received) in the monthly report. The state should report the “door” through which these applications were received in the “Applications Received by SBM” breakout in indicators 4d or 5d. An individual who applies for coverage via the SBM but does not request financial assistance should not be counted in these indicators, as those applications will not undergo an assessment or determination of Medicaid/CHIP eligibility.

Indicator 6: Number of Electronic Accounts Transferred

- 1. We are an FFM state. If the FFM will not be transferring accounts to us until November 2013, what should we report in the “electronic accounts transferred” indicator?***

If the FFM does not transfer any accounts to the state before November 1, then the total transfer accounts received by the state (indicators 6a-6h) for reporting periods prior to November should be left blank as it is non-applicable. However, if the state is transferring electronic accounts *to* the FFM in October, those should be recorded as transfer accounts sent by the state (indicators 6i-6k). If the state is unable to send or receive electronic account transfers until November, please leave these fields blank throughout this measure and explain in the data limitations text field that systems issues prevented your state from sending electronic accounts to the FFM in October.

- 2. Please clarify how SBM transfers are captured in indicator 6?***

Because all SBMs are integrated with Medicaid and CHIP (with one exception) there should be no transfer activity reported in indicators 6a-6k in SBM states. Also, because all Medicaid and CHIP systems in every state are now integrated, there should be no transfer activity reported between Medicaid and CHIP.

- 3. My state is changing the eligibility limit in our 1115 demonstration and some individuals will now be transferred to the Marketplace. How should that be reported?***

In FFM states, individuals who are transferred electronically to the Marketplace should be reported in indicators 6i (total transfer accounts sent) and 6j (transfers to FFM). As noted above, SBM states (with one exception) should report no transfer activity, as SBM and Medicaid/CHIP eligibility systems are integrated.

Indicator 7: Number of Renewals up for Annual Redetermination

1. *Does the renewals indicator include all individuals who are due for renewal, or only those who have been determined? Should it include those who receive a redetermination outside of the annual renewal cycle?*

The renewals indicator should include those individuals that come up for annual renewal within the month, regardless of whether those individuals receive an eligibility determination within the month.

For example, if a state had 15,000 individuals come up for annual renewal in October 2013, and of this number 12,000 responded to the request for verification information, with 10,000 determined eligible, 1,000 determined ineligible, and 1,000 still pending determination as of October 31st, all 15,000 individuals who came up for annual renewal should be counted in the indicator 7a reported in the October 2013 data. Those individuals should also be counted in either 7b (Medicaid renewals that will be determined under MAGI rules), 7c (Medicaid renewals that will be determined under non-MAGI rules), or 7d (CHIP renewals).

The outcome of the annual renewal process should be captured in other indicators. In the example above, we would expect that:

- The 10,000 individuals determined eligible would be reported in indicator 9 (individuals determined eligible)
- The 1,000 who were determined ineligible and the 3,000 whose accounts were closed due to lack of response would be reported in indicator 10 (individuals determined ineligible)
- The 1,000 whose redetermination was still pending as of the last day of October would be reported in indicator 11 (pending applications/renewals)

Indicator 8: Total Enrollment

1. ****What is the difference between the “individuals determined eligible” and “total enrollment” indicators? Aren’t these measuring the same thing?***

Indicator 9 (total number of individuals determined eligible) is counting the number of determination actions made by your Medicaid or CHIP agency. For example, a person who applied in October 2013 and was determined eligible in November 2013 would be counted as determined eligible in November 2013 since that is the month the determination action occurred.

Indicator 8 (total enrollment) is a point-in-time estimate of the total number of individuals enrolled in Medicaid or CHIP as of the last day of the reporting period (either the week or month). It should not be restricted to only those who newly enrolled in Medicaid/CHIP during the month. For example, a person who applied, was determined eligible, and enrolled in November 2013 and remained enrolled through mid-February 2014 would be counted in indicator 8 during the November 2013 reporting period, the December 2013 reporting period, and the January 2014 reporting period.

2. ***Within the enrollment indicator, should the number reported for “Total Medicaid enrollees” (indicator 8a) contain the sum total of CHIP enrollees and traditional Medicaid enrollees, while “Total CHIP enrollment” (8h) contains only CHIP enrollees?***

No. Indicator 8a (total Medicaid enrollees) should contain only those covered under Title XIX. Total number of CHIP enrollees should be reported separately in indicator 8h. The sum of these two fields should equal the total number of unduplicated Medicaid and CHIP enrollees in the state.

3. ***If an individual is determined to be eligible in October, but that eligibility will not begin until January, how should that individual be reported in the “enrollment” and “determined eligible” indicators?***

All individuals should be included in the indicator 9 (total individuals determined eligible) only for the reporting period in which the determination was made. Individuals should be included in indicator 8 (total enrollment) for each reporting period during which they are enrolled. In your example, the individual should be included in indicator 9 (total individuals determined eligible) for the month of October and for the weekly reporting period in October during which the determination was actually made. However, the individual would not be included in the indicator 8 (total enrollment) until January, when he or she actually became a Medicaid enrollee. That individual should then be included in indicator 8 for every reporting period thereafter until he or she disenrolls.

4. ***When you talk about total enrollment, do you want an unduplicated number? So if someone is in multiple programs, we will report them as only one person?***

Yes, if states are able to de-duplicate individuals who are enrolled in multiple programs, we would like an unduplicated number of individuals enrolled in Medicaid or CHIP as of the last day of the reporting period. If systems limitations prevent a state from de-duplicating this data, we ask that you note that in the data limitations text field.

5. *Should the enrollment indicator include spend-down enrollees and/or emergency Medicaid enrollees, who may transition on and off the program from month to month?*

States should report only those individuals receiving comprehensive Medicaid benefits. For example, individuals eligible for only a limited benefit package (i.e., individuals only eligible for emergency Medicaid, family planning services, etc.) should not be included.

6. **Are individuals with a share of cost reported in total enrollment?*

Individuals who become eligible for Medicaid through share of cost (or the medically needy program) should be counted in indicator 8 (total enrollment) if they qualify for comprehensive benefits.

7. **Should we report enrollees of our state's 1115 waiver program in the "total enrollees" count?*

If individuals in your state's 1115 waiver program are eligible for a comprehensive medical benefits package, then they should be included in indicator 8 (total enrollment). If the 1115 waiver provides only limited benefits (for example, covering only basic primary care visits), then these individuals should not be included in indicator 8. If you would like to discuss the specifics of your state's 1115 waiver program to determine whether to include it in the total enrollment indicator, please contact CMS.

8. **Should individuals with limited benefits be excluded from any counts other than total enrollment?*

No; please exclude individuals eligible for limited benefits from indicator 8 (total enrollment) only, and not from other indicators. As discussed below, the enrollment and determined eligible numbers will not be directly comparable.

9. **Are states required to update eligibility counts retroactively for greater accuracy? For example, a data pull later in the month will have a higher eligibility count for the prior month than a data pull right after the close of the month because additional beneficiaries will have been made retroactively eligible during that time.*

Yes, states must update all their prior month indicators (with the exception of indicators 1-3, which relate to call centers and 4 which is a weekly indicator) when they submit the next month's monthly report. For example, when submitting the November monthly report (on December 6th), the state should also update its October data to show any retroactive enrollments or other adjustments. When submitting its December report, the state need not update any data from October, but it must update its November monthly data.

Indicators 9 and 10: Individuals Determined Eligible or Ineligible for Medicaid or CHIP

1. Is the eligibility indicator intended to include those who were determined eligible in the prior month?

Indicator 9 (individuals determined eligible) is intended as a count of individuals who were determined eligible during the reporting period—either during the previous Sunday-Saturday (weekly report) or the previous calendar month (monthly report).

2. What is the difference between the “individuals determined eligible” and “total enrollment” indicators? Aren’t these measuring the same thing?

Indicator 9 (individuals determined eligible) is counting the number of people for whom your agency made a determination action. Generally, a person will be counted in only one reporting period in indicator 9—for example, a person who applied in October 2013 and was determined eligible in November 2013 would be counted in November 2013 only. The next time this person would be counted in this metric would be when they were re-determined as part of the annual renewal process (for example, in November 2014) or if they disenrolled and re-applied at a later date.

Indicator 8 (total enrollment) is a point-in-time estimate of the total number of individuals enrolled in Medicaid or CHIP as of the last day of the reporting period (either the week or month). It should not be restricted to only those who newly enrolled in Medicaid/CHIP during the month. For example, a person who applied, was determined eligible, and enrolled in November 2013 and remained enrolled through mid-February 2014 would be counted in indicator 8 during the November 2013 reporting period, the December 2013 reporting period, and the January 2014 reporting period.

3. *Should the sum of the number of individuals determined eligible (9a) and number determined ineligible (10a) equal the total of applications received (4a/5a) each week or month?

No, we would not expect these numbers to match, for the following three reasons:

- The unit of measure in indicators 4 and 5 (applications received) is “applications,” which in many cases will contain more than one person who will receive a determination. The unit of measure in indicators 9 and 10 (number determined eligible and ineligible) is “individuals” (which can also be thought of as determination actions). Even if every application received in a given reporting period was processed and received a final determination in the same period, we would not expect the indicators to match because of the differences in the units being counted.

- Applications should be counted in the reporting period in which they are received, while determinations should be counted in the reporting period during which they occurred. It is likely that applications received toward the end of the reporting period will not be processed and receive final determinations until subsequent reporting periods.
- The top-line number of individuals determined eligible and ineligible for Medicaid or CHIP (indicators 9a, 9h, 10a, and 10h) should include all determinations and redeterminations made during the reporting period, and not only those that are linked to an initial application for benefits. Specifically, individuals who receive a redetermination because they came up for annual renewal should be included in indicators 9a and 10a (number determined eligible and ineligible) but not in indicators 4a and 5a (applications received). Similarly, individuals receiving a redetermination due to a change in circumstance outside the annual renewal process should be counted in indicators 9a and 10a, but would not be counted in indicators 4a and 5a.

4. *If an individual has been eligible in the past and just completed a redetermination under which they were determined to still be eligible, should they be counted in the “determined eligible” indicator?*

Yes. Individuals should be counted in indicator 9 (individuals determined eligible) each time that a determination is made, regardless of their previous enrollment status. In this case, the individual should be counted in either indicator 9a (total Medicaid eligible) or 9h (total CHIP eligible), as well as in either indicator 9e (Medicaid eligibility determined at annual renewal) or 9j (determined CHIP eligible at annual renewal).

In general, we would expect an individual to be counted either in indicator 9 or 10 at each of the following events: (1) when determined eligible or ineligible at initial application; (2) when determined eligible or ineligible at annual renewal; (3) when determined eligible or ineligible at an unscheduled redetermination due to a change in circumstance; and (4) if they re-apply after leaving the program and receive a new determination of eligibility or ineligibility.

5. **Our state is using its legacy rules determination engine for all determinations until January 1, 2014. How should we report the number of eligibility determinations (indicators 9 and 10)? How should we report the MAGI versus non-MAGI splits?*

If your state is not implementing the new eligibility rules until January 1, 2014, you can report these eligibility determinations as “non-MAGI.”

6. *Our state is accepting new applications for MAGI-based Medicaid starting in October, but we won’t enroll this new population until January 1, 2014. How should this be reported in the number of eligibility determinations (indicators 9 and 10) and in total enrollment (indicator 8)?*

Determinations should be reported in the month that the agency made the determination, even if that is not the same month in which the person was able to enroll in the program. For example, if an individual was determined eligible for Medicaid under MAGI rules in November 2013, but was not enrolled in Medicaid until January 1, 2014, the state should report this individual in indicator 9a (total Medicaid eligible) in the November 2013 reporting period and in indicator 8a (total Medicaid enrollees) starting in the January 2014 reporting period. Note that the individual would be included in indicator 8a in every month during which they were enrolled, not just the first month.

7. *Please clarify how FFM transfers are captured in the eligibility determinations indicators?*

In determination states, the FFM will make (and report on) the determination, so these states should not report these individuals in indicator 9 (the number of individuals determined eligible) or indicator 10 (the number of individuals determined ineligible). In assessment states, the state should count transfers from the FFM in indicator 9 (the number of individuals determined eligible) or 10 (number of individuals determined ineligible), as appropriate. When reporting determinations by reason for determination, these transfers should be reported as determinations made at application (indicator 9d or 10d). In both determination and assessment states, individuals determined eligible should be included in indicator 8 (total enrollment) once the individual's coverage begins.

8. *Can you explain why individuals determined eligible by the FFM should not be included in the “determined eligible/ineligible” indicators?*

This is to avoid double-counting. Since CMS will already be tracking and reporting the FFM eligibility determinations, these determinations should not be duplicated in the data that states are reporting to us.

9. *What are “administrative determinations” in the data break-out for the “number determined eligible” (indicator 9f)?*

Some states received approval from CMS to implement a targeted enrollment strategy that allows for an administrative transfer, such as enrolling SNAP beneficiaries into Medicaid. See the CMS May 17, 2013 State Health Official letter on targeted enrollment strategies for more details.

10. *Does “administrative determination” (indicator 9f) also refer to Express Lane Eligibility automated renewals?*

“Administrative determination” (indicator 9f) only applies to the targeted enrollment strategies described in the May 17, 2013 State Health Official Letter and does not include those determined eligible through Express Lane Eligibility.

11. *How do we know if we are a state approved to use targeted enrollment strategies?*

A list of states approved to use any of the available targeted enrollment strategies is available at <http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html>.

- 12. **My state is transferring a group of individuals from SNAP, consistent with CMS’ “targeted enrollment strategies.” When should we count these individuals as determined eligible - when they return a signed form or respond via phone?***

The state should count individuals as determined eligible in indicator 9a (total Medicaid eligible) when they have taken all steps the state has deemed necessary for establishing eligibility. In the ‘by reason for determination’ break-out, these individuals should be reported in indicator 9f (Medicaid eligible via administrative determination). As these individuals are not submitting an application, but rather having their eligibility information administratively transferred from another program, they should not be counted in indicators 4 or 5 (total applications received).

- 13. *If an individual is determined to be eligible in October, but that eligibility will not begin until January, how should that individual be reported in the “enrollment” and “determined eligible” indicators?***

All individuals should be included in indicator 9 (individuals determined eligible) during the reporting period in which the determination was made. Individuals should be included in indicator 8 (total enrollment) for each reporting period during which they are enrolled. In your example, the individual should be included in the indicator 9 for the month of October and for the weekly reporting period in October during which the determination was actually made. However, the individual would not be included in indicator 8 until January, when he or she actually became a Medicaid enrollee. That individual should then be included in the enrollment indicator for every reporting period thereafter until he or she disenrolled.

- 14. *Previously, states were asked to only classify individuals as MAGI if they were determined under MAGI rules, and not if they were a member of a group that would be determined under MAGI rules in the future. We now learned that states are welcome to classify individuals determined under non-MAGI rules as MAGI, as long as they include a note in the data limitations field explaining how they did so. Our state corrected (i.e. removed) baseline data with MAGI breakouts. Would you prefer us to resubmit baseline with MAGI breakouts and the explanation of how we arrived at these breakouts?***

No, you do not need to resubmit your baseline data. Going forward, please simply continue to provide data following the logic you used in your most recent submission. Consistency will be important as we seek to understand trends in your data.

15. ****For individuals who are first determined eligible under MAGI, but then are determined eligible on a non-MAGI basis within the same reporting period, should we report one determination or two?***

Both determinations should be counted in indicator 9a (total Medicaid eligible). This means that it is possible (if both the non-MAGI determination and the MAGI determination are completed within the same reporting period) that one individual could have two eligibility determinations in the same reporting period.

16. ****How should we report on individuals whose eligibility information is transferred administratively through a process other than the ones available through the May 17th SMO letter (for example, SSI recipients who are auto-enrolled, or enrollments via Express Lane Eligibility [ELE] programs)? Should these individuals be counted in the applications indicator and/or the determinations indicator?***

Individuals who enter a state's eligibility determination system via an administrative data transfer rather than by submitting an application should not be counted in indicators 4 or 5 (total applications received). This would be the case for SSI recipients who are auto-enrolled into Medicaid; ELE determinations; and transfers from an existing 1115 demonstration.

These individuals should, however, be counted in the determinations reported in indicator 9 (total Medicaid eligible). They should also be reported in 9g (Medicaid eligible via other method), and not in 9f (Medicaid eligible via administrative determination). When states report individuals in indicator 9g (Medicaid eligible via other method), a description of how these individuals were determined eligible (e.g. through ELE processes) should be included in the data limitations field. The only determinations that should be included in element 9f (Medicaid eligible via administrative determination) are those made through the targeted enrollment strategies outlined in the May 17th SMO letter.

17. ****My state is changing the eligibility limit in our 1115 demonstration and some individuals will now be transferred to the Marketplace. How should that be reported?***

If your state is ending coverage, consistent with your 1115 demonstration transition plan, your state should do a determination to ensure that individuals are not eligible for any other categories of coverage. These determinations should be counted in indicator 9 (individuals determined eligible) or indicator 10 (individuals determined ineligible), as appropriate. If these individuals are over income for the new standard, your state should report them in indicator 10b (Medicaid determination - ineligibility established) and 10f (Medicaid determination – ineligible via other application type).

In FFM states, individuals who are transferred electronically to the Marketplace should be reported in indicators 6i (total transfer accounts sent) and 6j (transfers to FFM). In SBM states (with one exception), no transfer activity should be reported.

18. *My state is moving a group of people from an existing 1115 demonstration into the new adult group in Medicaid. How, when, and where should these individuals be reported in the performance indicators?

In the week/month the state makes a determination regarding eligibility for the new adult group for these individuals they should be reported in indicator 9 (individuals determined eligible) or indicator 10 (individuals determined ineligible). Within the ‘by reason for determination’ break-out, these individuals should be reported in 9g (Medicaid eligible via other method) and not in 9f (Medicaid eligible via administrative determination). A description of how these individuals were determined eligible (e.g., transfer of a group formerly covered under a demonstration) should be included in the data limitations field. In any month in which the individuals are enrolled in comprehensive coverage (whether that is through the 1115 demonstration or through the new adult group) they should also be reported in indicator 8 (total enrollment).

19. *How should we categorize presumptively eligible individuals in the performance indicators?

Those individuals determined presumptively eligible should not be included in indicator 9 (the number of individuals determined eligible). Only those individuals receiving a “final determination” are included in this count. These individuals should also be excluded for indicator 8 (total enrollment) and indicator 12 (processing time).

Indicator 11: Pending Applications and Renewals

1. *Should the “pending” indicator include those in the queue to be worked, or only those cases where processing has begun but cannot be completed until additional information is received?*

Indicator 11 (pending applications and renewals) should include all those in the queue. That is, it should include all applications and redeterminations that are in process but not complete for any reason, whether that is due to outstanding verification items on the part of the applicant or merely the normal processing time needed by the Medicaid or CHIP agency to make a determination.

2. *Does the pending applications/renewals indicator include all accounts that are still undetermined, or only those that are failing to meet the timeliness standard? Should this indicator include online applications that are initiated but not yet submitted?*

Indicator 11 (pending applications and renewals) should include all applications that are received by the agency but have not yet been determined within the reporting period. It is a point-in-time count on the last day of the month. This indicator should include only those applications that have been formally submitted to the Medicaid program, but not online applications that have been initiated and not yet submitted to the agency.

Indicator 12: Processing Time for Determinations

1. *For processing time for determinations, how should we handle delays because of outstanding verification items on the part of the applicant? Should that be included in the lag time?*

Yes, indicator 12 should include the number of days between the date the Medicaid agency received the application to the date the determination was made. Delays caused by the applicant due to outstanding verification items should be included in the processing time.

2. *If the FFM won't be transferring applications to us until November 1, do we need to include those 30 days in our reports of processing time?*

No. Transfer application included in the calculations for indicator 12 should count the number of days that elapse between the date the Medicaid agency received the application from the FFM, and the date the final determination is made. If the Medicaid agency does not receive an account from the FFM until November 1st, the clock will “start” on November 1st and not on the date the applicant initially submitted the application to the FFM.

3. *For individuals who are first determined under MAGI, but then also request a non-MAGI determination, how should processing time be measured and reported?*

Processing time should be measured and reported separately for each determination. Processing time should be calculated from receipt of the application to the first determination (MAGI), and then from the time of the MAGI determination (or the time of the request for a non-MAGI determination if that request was not made on the application) to the time of the non-MAGI determination.

4. **Please clarify how transfers are captured in the indicators for processing time?*

In assessment states, the state should calculate the time to process from the time the transfer was received by the Medicaid or CHIP agency to the time the individual was determined eligible or ineligible. Determination states should not include transfers from the FFM in calculating processing time for indicator 12.